Washington State's Individual Market in Perspective

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by the Washington State
Office of the Insurance Commissioner

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Executive Summary

Under Washington State's health insurance reforms, insurers cannot turn down applicants because of their health status. Washington residents also have the right to change carriers without risking their coverage – or serving new waiting periods during which they cannot use their insurance. Finally, health insurance in Washington State can only be canceled when a subscriber stops paying for it.

These reforms have been in effect for nearly five years, but policy makers are being given conflicting information about their effect, especially on the individual market. Some carriers blame the reforms for today's problems in the individual market, suggesting that the reforms should be repealed or seriously modified. This memorandum addresses those concerns in the context of many factors that influence our health insurance marketplace.

Significant findings

1. Washington State's 1994 reforms successfully addressed consumers' complaints that they had been locked out of the private insurance market.

- The rate of uninsured in Washington declined from 13% in 1996 to 11.4% in 1997, while the uninsured rate in the rest of the U.S. increased from 15.6% to 16.1%.
- Twenty-two percent of state residents who entered coverage following the 1994 reforms were previously uninsured.
- At 10 town hall meetings around the state in late 1998, consumers report that today their biggest concerns are the roadblocks erected by their insurers that prevent them from accessing medical services.
- The current public policy debate is focused on the individual market. The individual market contains 5% of the state's residents. Some 4,000,000 state residents are coping with the problems of managed care.

2. Market segmentation has segregated the healthy from the sick and provides incentives to consumers to move between plans.

- Maternity benefits are only available in 14 percent of the plans offered by the three largest carriers in the individual market.
- The isolation of maternity and other potentially expensive benefits in limited number of plans has concentrated the risks and claims costs, and priced these plans out of the reach of most consumers.
- This business practice by insurers has forced higher-risk consumers to the Basic Health Plan, contributing to the need for BHP premium hikes.

3. The most serious "losses"[1] for the health insurance industry are occurring in the group markets, not the individual market.

- Large groups lost $43,809,935 in 1997 – almost four times the $11,921,907 lost on individual products.
- Individual market claims in 1997 amounted to 83.77% of premiums collected; in the large group market, claims costs were 88.07% of total premiums.
- Premiums collected by Premera Blue Cross consistently covered the cost of medical claims from 1992 to 1997. However, the carrier's administrative costs have increased 209% over the same period.
- Some of the health carriers with the greatest losses in 1997 are not participants in the individual market. But the state's largest health carrier, Regence BlueShield, is a participant in the individual market and finished 1997 in the black, thanks in part to the $2.6 million more in premiums it collected from individuals than it paid out in claims and non-claims expenses.

4. A study shows consumers do not wait until they are ill to buy coverage.

- According to a University of Washington study, 95 percent of the new subscribers who enrolled under the initial reforms in 1994 were still insured two years later.
- 90 percent of the women who filed maternity claims within nine months of enrollment also remained covered two years later.
- The study confirmed that individuals did move among plans. However, the reasons for changing were changes in employment or residence, better premiums rates, or staying with a specific doctor who moves to the network of a different carrier.
- This finding reflects that the individual market has always been and continues to be transitional in nature.

5. Solutions that will help consumers must focus on key concerns.

Any effective solutions will:

- Minimize costs by spreading risk broadly, involving the highest number of consumers possible.
- Make benefits uniformly available so that consumers can access health care without difficulty when it is needed.
- Measures that limit individual access to insurance will not significantly alter the financial picture for Washington carriers.
- Solutions also need to address: 1) controlling rising administrative costs and 2) safeguarding that managed care produces more efficient care and does not erect roadblocks to needed care.

[1] When carriers discuss "losses," confusion often arises. Generally, the term is used to describe "underwriting losses," which occur when total premiums do not cover total claims and administrative expenses related to a particular line of business. This use of the term does not indicate net losses at a carrier's bottom line. See Page 6 for a more complete discussion of loss.

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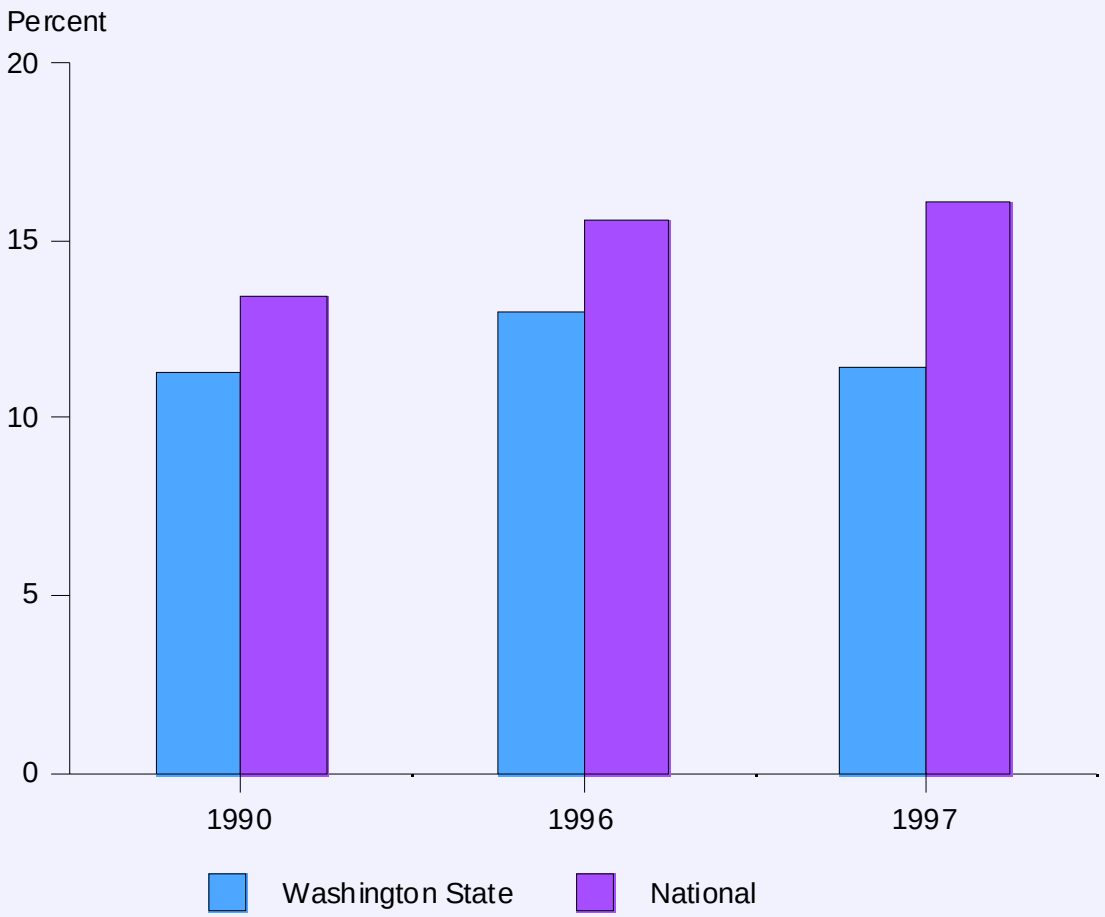
SECTION ONE

Washington State's 1994 reforms successfully addressed consumers' complaints that they had been locked out of the private insurance market.

THE NUMBER OF UNINSURED IN WASHINGTON IS NOT INCREASING

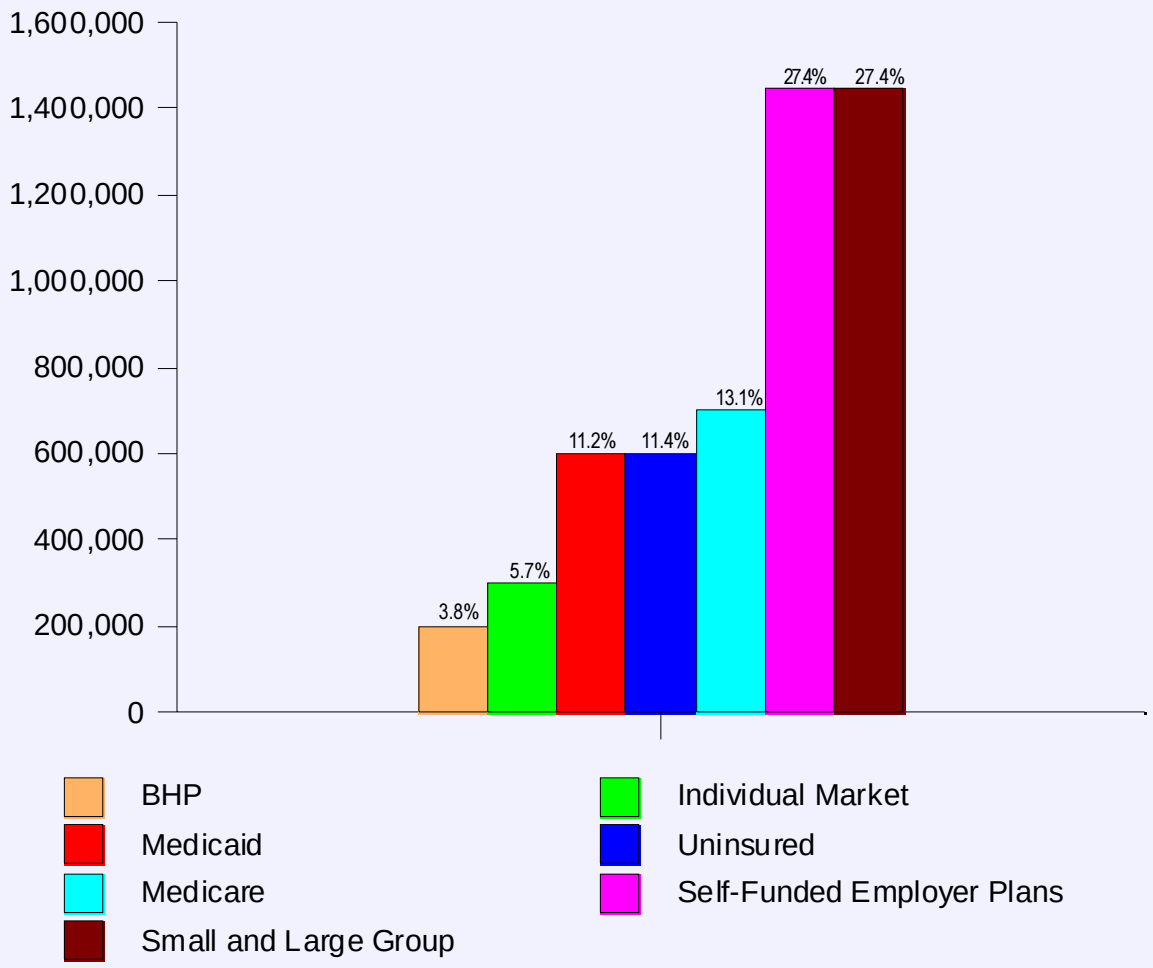
FIGURE 1: WASHINGTON STATE'S UNINSURED RATE



Washington State's 1994 reforms have provided access to health coverage. The state's uninsured population has remained remarkably steady over the past six years, despite rising numbers nationally. In addition, a University of Washington study found that 22 percent of those who signed up for coverage in the wake of reform had previously been uninsured.

INDIVIDUAL INSURANCE IS A SMALL CORNER OF THE MARKETPLACE

FIGURE 2: MAJOR HEALTH INSURANCE MARKETS IN WASHINGTON STATE



Only the state's Basic Health Plan ranks below individual insurance in the overall marketplace. Washington state's individual market only serves about 5 percent of the state's insured population and about 7 percent of the commercially insured.

This fact has remained unchanged over the past several decades.

SECTION TWO

Market segmentation has segregated the healthy from the sick and provides incentives to consumers to move between plans.

STRUCTURE OF BENEFITS CAN BE USED TO SEGREGATE HEALTHY AND SICK

FIGURE 3: MARKET SEGMENTATION BY BENEFIT DESIGN

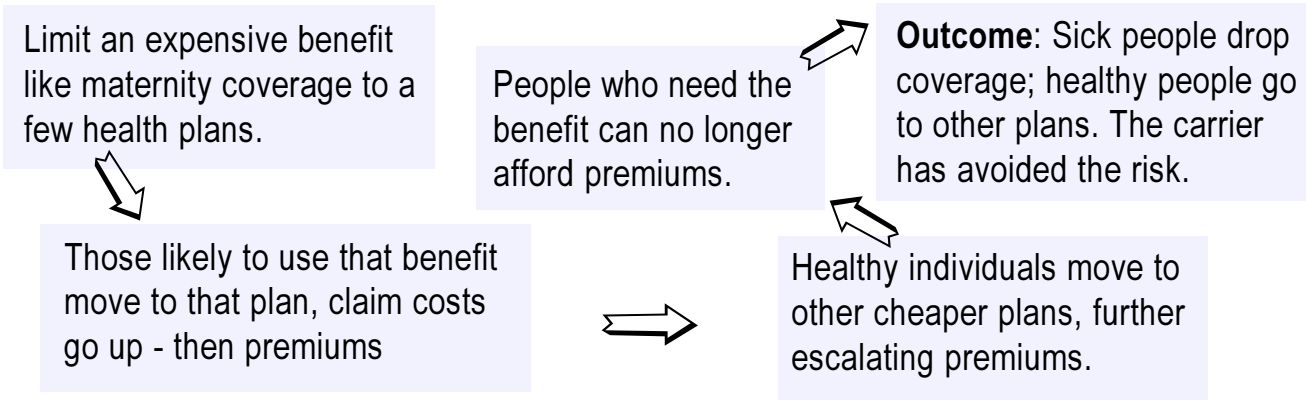
Carrier	Plan Name	Preventive	Maternity	Health	Mental Rehab	Rx	Wellness
Premera Group							
Blue Cross of WA & AK	Model Plan	Yes	Yes	Yes	No	Yes	No
	Plan A 15	Yes	No	Yes	No	Yes	No
	Traditional	No	No	No	Yes	Yes	No
	Prudent Buyer Sense 750/20	No	No	No	Yes	Yes	No
	BasicOne	No	No	No	Yes	No	No
Medical Service Corp.	Prime Care 20	Yes	Yes	Yes	Yes	Yes	No
	Preferred Provider Org. 750	No	Yes	Yes	Yes	Yes	Yes
Group Health Cooperative	Model Plan	Yes	Yes	Yes	No	Yes	No
	Major Medical	Yes	No	Yes	Yes	Yes	Yes
	$500 Deductible	Yes	No	Yes	Yes	Yes	Yes
Regence Blue Shield	Model Plan	Yes	Yes	Yes	No	Yes	No
	Selections 96	Yes	No	No	Yes	Yes	No
	Passport	Yes	No	No	Yes	Yes	No

This chart shows a sampling of popular individual products offered by the three largest carriers in the individual market in September 1998. With the exception of MSC in Eastern Washington, maternity coverage has been limited to the state's Basic Health Plan and its commercial alternative, the Model Plan. In total, only 14 percent of the individual products offered by these three carriers include comprehensive maternity benefit.

Similar efforts have been made to manipulate risk with prescription drug benefits. These can be made difficult to access because of co-pays, limits on which medical conditions prescriptions may be offered, etc.

MARKET SEGMENTATION WORKS BY MANIPULATING BENEFIT PACKAGES

FIGURE 4: HOW MARKET SEGMENTATION WORKS



Market segmentation is outlined in this chart. The purpose of these practices is to avoid covering risk. The basic premise of insurance is to spread the cost of covering risk by spreading it across as large a population as possible. Market segregation runs counter to this basic premise because:

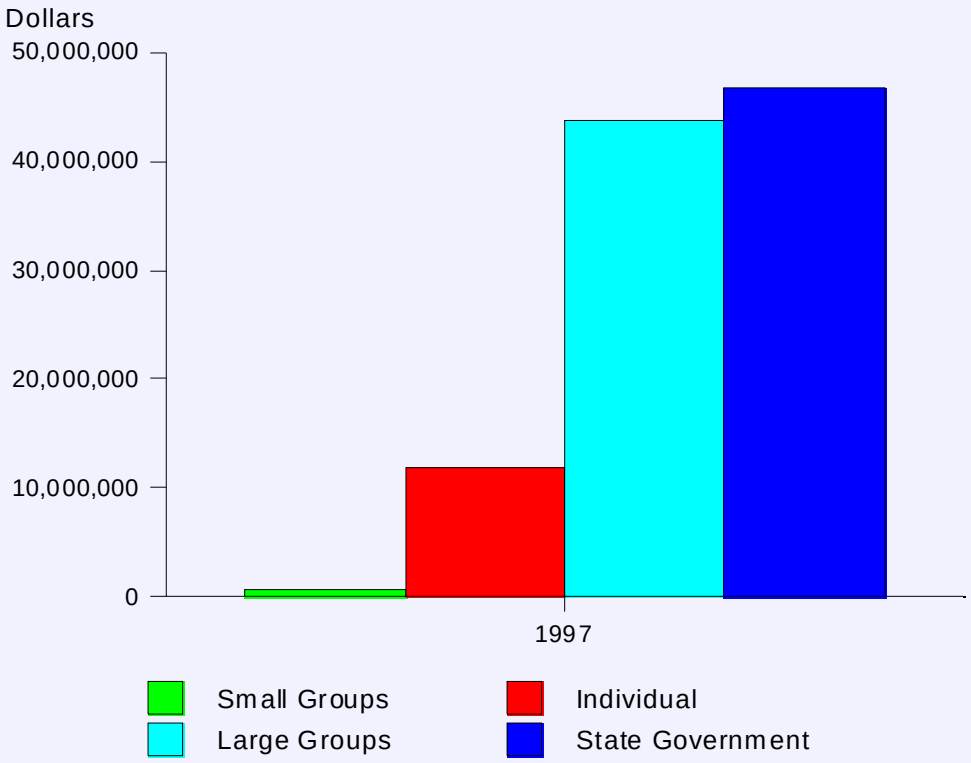
- Risk is not spread evenly across the market, but concentrated in small pockets.
- Health insurance pricing begins to put coverage out of reach except for the healthy.

SECTION THREE

The most serious "losses" for the health insurance industry are occurring in the group markets, not the individual market

LARGE GROUP MARKET TURNS IN BIGGER LOSSES THAN INDIVIDUALS

FIGURE 5: LOSSES BY MARKET CATEGORY IN 1997



Although insurance carriers have complained about their losses in the individual market, they traditionally have lost far more in the large group markets with large employers. In 1997, for example, large groups lost $43,809,935 in 1997 – almost four times the $11,921,907 lost on individual products.

UNDERSTANDING THE TERM "LOSSES" IN THE INSURANCE CONTEXT

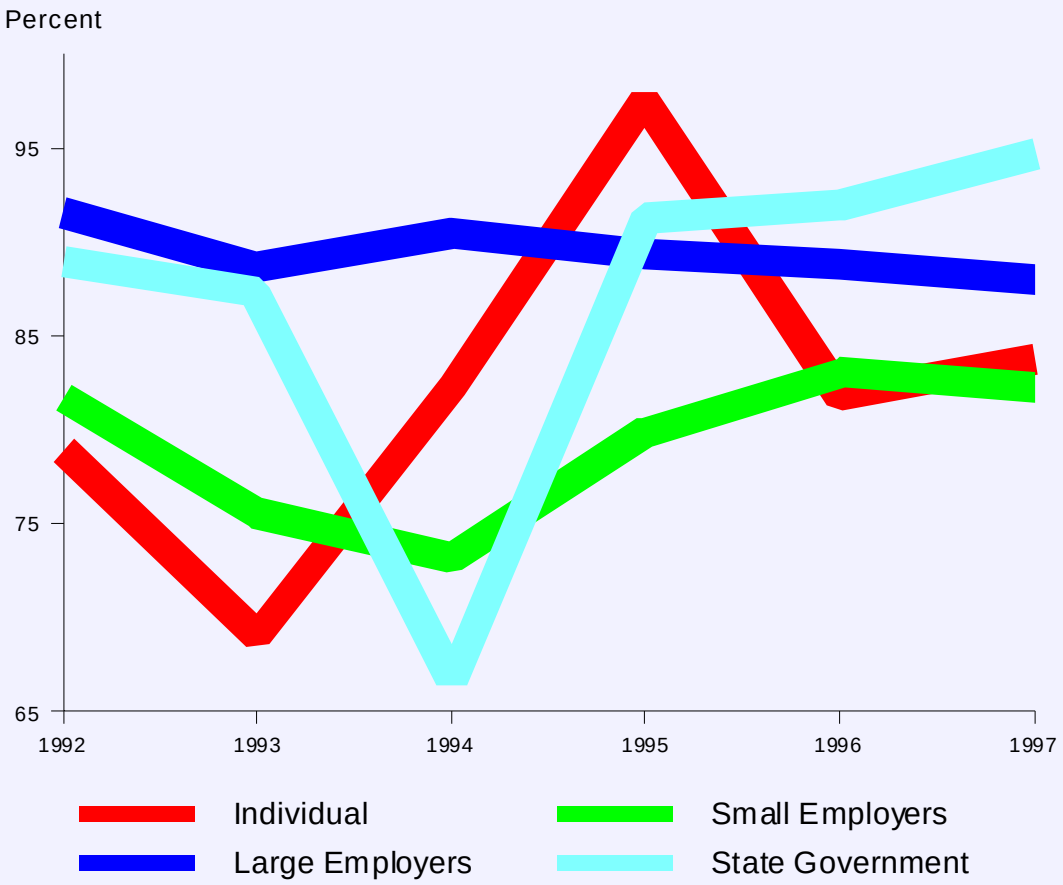
The insurance industry uses "losses" to mean several different things. The **"loss ratio"** commonly cited by insurers has nothing to do with "losses" at all. Rather, it refers to the percentage of total premiums that were required to pay total claims from subscribers. ("Claims ratio" would be a much more accurate term.)

"Underwriting loss" describes cases in which total claims and administrative costs exceed total premiums. Due to investment income earned from the premiums collected, this figure still is not a loss at the carrier's bottom line.

Finally, true operational losses, or negative **net income**, only occurs when the insurer's income from all sources (including investment of premiums) exceeds expenses and writeoffs.

INDIVIDUAL SUBSCRIBERS TURN IN FEWER CLAIMS THAN GROUPS

FIGURE 6: "LOSS RATIOS" IN THE HEALTH INSURANCE MARKET

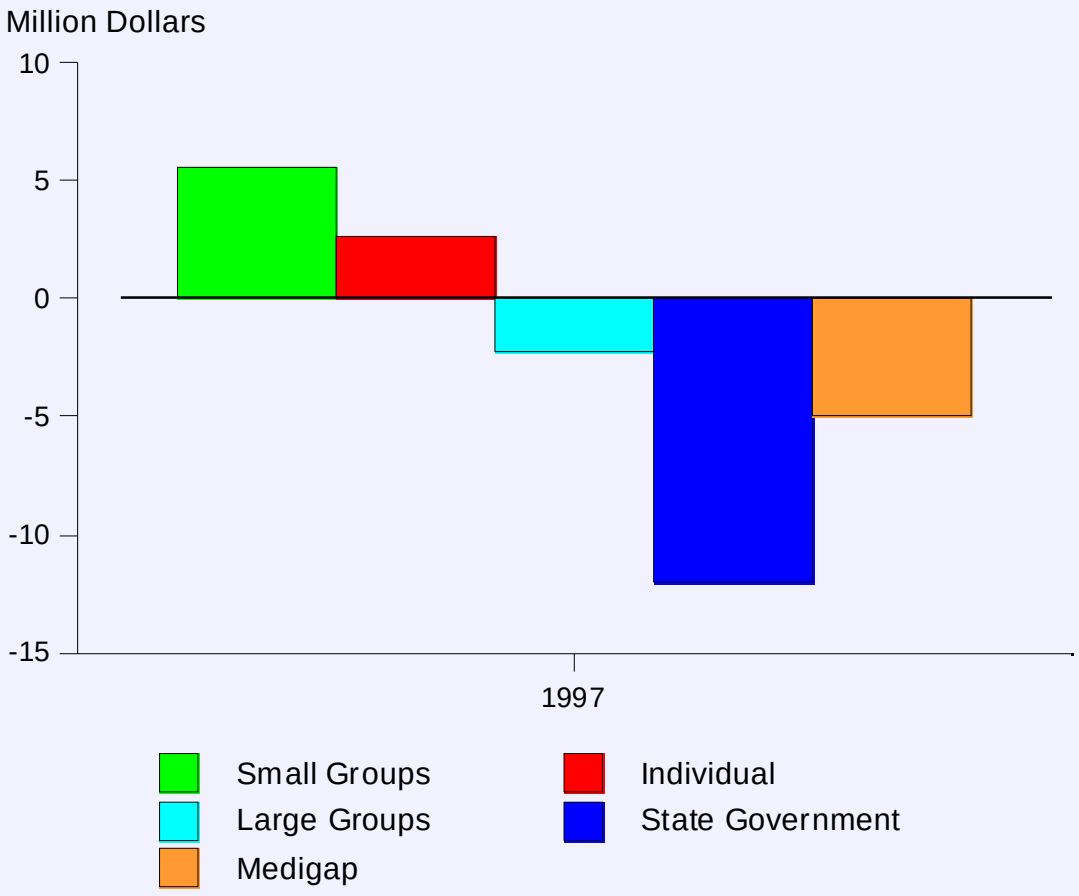


	1992	1993	1994	1995	1996	1997
Individual	78.97%	69.12%	82.39%	97.58%	81.83%	83.77%
Small Employers	81.68%	75.52%	73.25%	79.95%	83.09%	82.2%
Large Employers	91.54%	88.65%	90.46%	89.4%	88.76%	88.07%
State Gov't	89.02%	87.27%	66.89%	91.22%	91.92%	94.75%

The loss ratios reported by large negotiated groups, including large employers like state government, far exceeded the level of claims in the individual and small group markets. Conventional wisdom holds that large-group market generates so much money for investment that carriers are not overly concerned about the higher claims cost and narrower underwriting margins.

REGENCE BLUESHIELD SHOWS PROFIT IN INDIVIDUAL MARKET

FIGURE 7: REGENCE BLUESHIELD UNDERWRITING LOSSES AND GAINS BY MARKET CATEGORY IN 1997



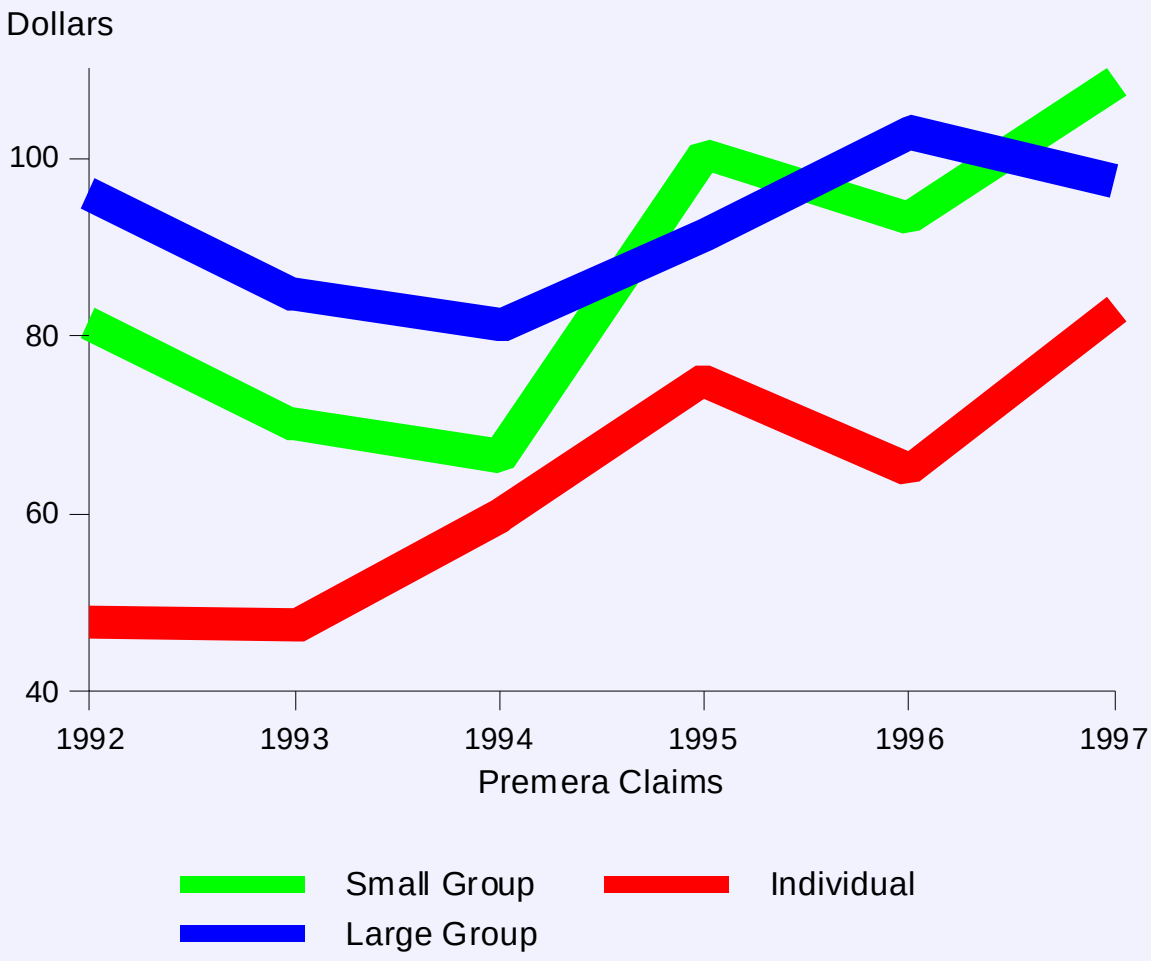
Some of the health carriers with the greatest losses in 1997 were not even participants in the individual market: Two of them, United Physicians of Washington and Providence Healthcare, both went out of business due to losses in the group and state government markets.

One health carrier with the best performance was a participant in the individual market. Regence BlueShield had an underwriting gain of $2.6 million on its individual business in 1997 — compared with losses of $5 million on Medigap policies, $2.3 million on large employer groups, and $12 million on government contracts.

In addition, Regence's return on investments ranged from $37 million in 1995 to $91 million in 1996, and $53 million in 1997. Regence continues to turn in a positive net income year after year. Its reserves improved each year from 1990 to 1995, and it continues stable in 1997 at a level well above the 1990 performance.

INDIVIDUAL MARKET CONSUMERS HAVE BEEN A BARGAIN

FIGURE 8: PREMERA'S CLAIMS LEVELS BY MARKET



Premera Blue Cross' claims experience also showed individual market claims as ranking consistently below the other markets.

ADMINISTRATIVE COSTS SHOW DRAMATIC RATE OF INCREASE

FIGURE 9: PREMERA BLUE CROSS (BCWA & MSC) PREMIUMS VS. CLAIMS

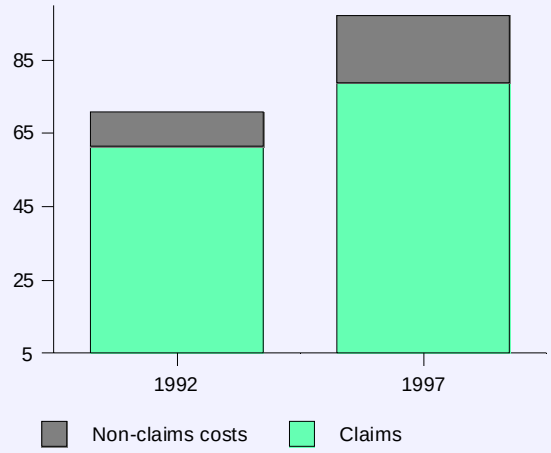


FIGURE 10: PREMERA BLUE CROSS (BCWA & MSC) PREMIUMS VS. CLAIMS

	1992	1993	1994	1995	1996	1997
Premium	$81,552,507	$103,539,742	$139,114,954	$176,198,161	$186,219,622	$195,771,162
Claims	60,279,843	75,555,863	123,489,585	185,736,186	155,981,364	172,210,150
Gain/Loss	***20,272,664***	***27,983,879***	***15,625,369***	***(9,538,025)***	***30,238,258***	***23,561,012***
Admin	$11,791,579	$14,624,076	$27,810,319	$38,303,358	$38,515,361	$36,478,882
Subscr's	105,160	132,738	172,235	206,444	199,649	172,601

Blue Cross' enrollment rose 60% between 1992 and 1997, administrative expenses increased 209%

In addition, Blue Cross claims data show that individual market enrollments increased between 1992 and 1997. As expected, premiums increased, too, and the surplus of premiums after claims were paid remained remarkly even. However, premiums did not cover the disproportionate increase in administrative expenses in the same period. While enrollments increased by 60% over the six years, administrative expenses increased at more than triple that rate, or 209%.

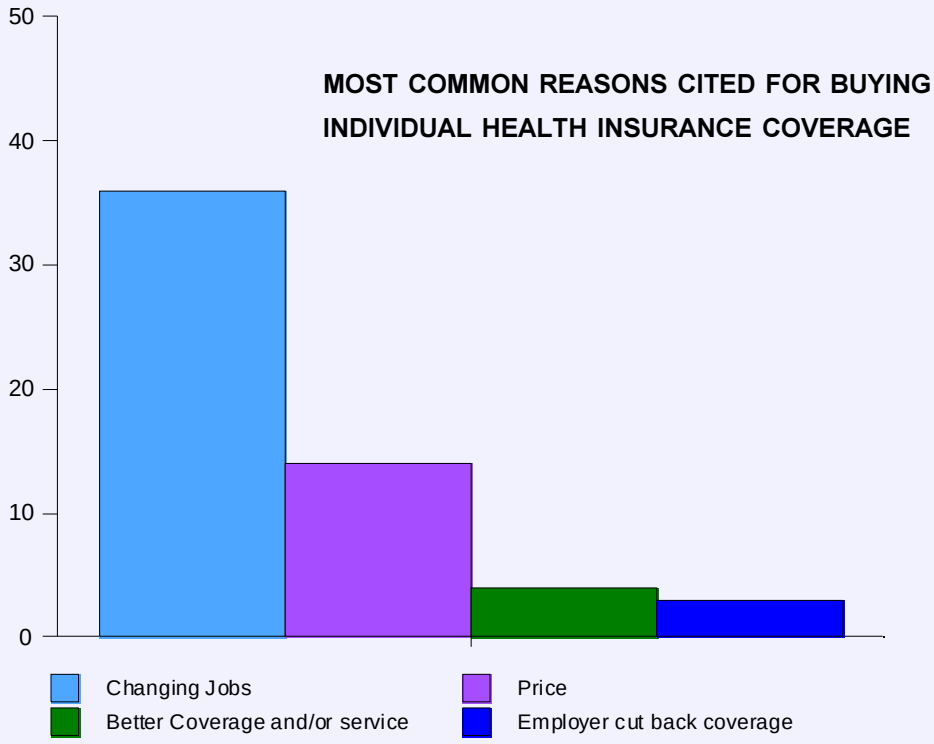
The trend toward higher administrative expenses occurred during the same period in which Washington state and the nation moved into an era of managed care. That fact suggests managed care's attempt to economize on the dollars paid to health-care providers would be better described as simply a shift in payments, from doctors to bureaucrats.

SECTION FOUR

A study shows consumers do not wait until they are ill to buy coverage

STUDY SHOWS THAT CONSUMERS DIDN'T "GAME THE SYSTEM"

FIGURE 11: KEY FINDINGS OF UNIVERSITY OF WASHINGTON STUDY



SOURCE: "INDIVIDUAL INSURANCE REFORMS AND OPEN ENROLLMENT," ROBERT CRITTENDEN, SUSAN CASEY, UW, 1997

A two-year University of Washington study provides further evidence that Washington consumers did not take advantage of health-care reform to "game the system," as insurers have repeatedly said. The study examined the coverage history of consumers who enrolled during the 1994 open enrollment period following the reforms.

Although some consumers switched plans over the study period, plan switching has been driven by considerations other than health needs. Further, despite the switches, 95% of the applicants who enrolled for coverage after the reforms went into effect remained insured two years later, including 90 percent of the women who filed maternity claims after their enrollment.

SECTION FIVE

Solutions that will help consumers must focus on key concerns

PUBLIC INTEREST ARGUES AGAINST ATTEMPTS TO SEGREGATE THE SICK

Any effective solution to the current market problems must:

- Minimize costs by spreading risk broadly, involving the highest number of consumers possible.
- Make benefits uniformly available so that consumers can access health care without difficulty when it is needed.

It is important for policy makers to understand that it is the plans themselves, not the consumers, who have created the incentive to move from plan to plan in the individual market. This occurred as health insurers tried to avoid risk – the antithesis of insurance.

The solutions also must focus on the real questions that rise from the marketplace:

- Why are administrative costs on the increase?
- Has the trend toward tighter-fisted budgeting and lower fees to practitioners purchased more efficient care — or simply more paperwork and red tape?